Date _____

Please fill out this form in detail.
The information will be used to assist the doctor in best serving you.
This information is confidential and will only be used for clinical purposes.

Patient Information

Name (First, MI, Last) _____ Preferred Name: _____ ☐ Female ☐ Male

Address: _____ Apt./Unit Number _____

City: _____ State: _____ Zip Code: _____

Cell #: _____ Work #: _____ Home #:_____

Email: _____ Birth Date: _____ SSN: _____ - _____ - _____

Occupation: _____ Employer or School: _____

Marital Status: ☐ Single ☐ Married ☐ Other Spouse's Name: _____

Name/Ages of Children At Home: _____

Name and Number of Emergency Contact: _____

How were you referred to Palmieri Chiropractic and Rehabilitation?

☐ Family Member ☐ Friend ☐ Doctor ☐ Internet ☐ Phone Book ☐ Other _____

Please list the name of the family member, friend or doctor that referred you: _____

Have you been to a chiropractor before? ☐ No ☐ Yes Approximate Date of Last Visit _____

Reason for Today's Visit

Chief complaint _____

How long ago did your symptoms begin? _____ Have you had this problem before? ☐ Yes ☐ No

How did this problem start? _____

Is the problem related to an auto/work accident? ☐ No ☐ Yes If yes, what is the date of the accident? _____

Describe your current pain: ☐ Dull Ache ☐ Sharp / Stabbing ☐ Numb/Tingles

Average pain intensity: (circle one) 0 1 2 3 4 5 6 7 8 9 10

Overall, my condition is: ☐ Getting Worse ☐ Getting Better ☐ Staying the Same

How frequently do your symptoms occur?

☐ Constant (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (0-25% of the time)

How much does your condition interfere with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, you would say your overall health right now is…

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What makes it better? _____

What makes it worse? _____

Have you seen anyone else for this condition? ☐ Yes ☐ No

If Yes, who? _____

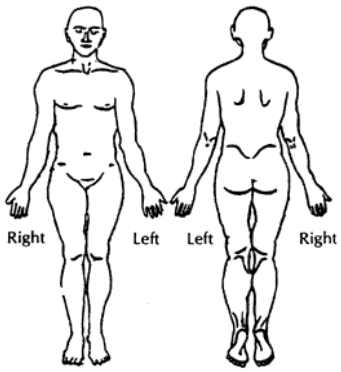
Type of treatment(s) tried _____

Results: _____

Secondary complaint (if applicable) _____

_____

Please mark all areas of concern.



FOR OFFICE USE ONLY:

_____
_____
_____
_____
_____
_____
_____

General Health History

Please indicate if you have or have had any of these conditions

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Shortness of Breath	☐	☐	Cancer _____
☐	☐	Migraines	☐	☐	Asthma	☐	☐	Diabetes Type I ____ II ____
☐	☐	Scoliosis	☐	☐	Low Blood Pressure	☐	☐	Fibromyalgia
☐	☐	Herniated/Bulging Disc	☐	☐	High Blood Pressure	☐	☐	Depression
☐	☐	Dizziness	☐	☐	Heart Disease	☐	☐	Anxiety
☐	☐	Fainting	☐	☐	Heart Pacemaker	☐	☐	Chronic Constipation
☐	☐	Trouble Sleeping	☐	☐	Heartburn	☐	☐	Chronic Diarrhea
☐	☐	Numbness	☐	☐	Dental or Jaw Problems	☐	☐	Poor Appetite
☐	☐	Multiple Sclerosis	☐	☐	Loss of Hearing	☐	☐	Enlarged Prostate
☐	☐	Parkinson's Disease	☐	☐	Ringing in Ears	☐	☐	Erectile Dysfunction
☐	☐	Stroke History	☐	☐	Loss of Vision	☐	☐	Menstrual Cramps
☐	☐	Arthritis	☐	☐	Frequent Colds	☐	☐	Irregular Periods
☐	☐	Osteoporosis/Osteopenia	☐	☐	High Stress Level	☐	☐	Tobacco Use- Packs/Day _____
☐	☐	Kidney Stones	☐	☐	Other _____			

Current Health Status

Average exercise level: ☐ None ☐ Light ☐ Moderate ☐ Intense

Frequency of exercise: ☐ Daily ☐ Occasionally ☐ Other _____

Describe your level of activity at work:

☐ Sedentary ☐ Active ☐ Physically Demanding

Do you take any medications or vitamins? ☐ No ☐ Yes

If yes, please list: _____

_____

Do you have any known allergies? ☐ No ☐ Yes

If yes, please list: _____

_____

Please list any past accidents / injuries: _____

_____

Please list any previous surgeries: _____

_____

Women: Are you / is there a possibility you may be pregnant? ☐ No ☐ Yes If yes, what is your due date? _____

Family History

Father: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Mother: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication Use □ Arthritis □ Other_____

Is there any other family history you want us to know? _____

Patient Name _____ Date _____

OFFICE POLICIES & PROCEDURES AGREEMENT

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic procedures, including examination, adjustment/manipulation, various modes of physiotherapy, and any supportive therapies on me (or on the patient below, for whom I am legally responsible) by the doctor of chiropractic and support team at Palmieri Chiropractic and Rehabilitation. I also understand that as is with all healthcare treatments, results of treatment are not guaranteed, and this office does not cure disease. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have been informed and I understand that in the practice of medicine, in this case chiropractic, there are risks associated with treatment, although rare, including but not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, and is in my best interest. This consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Financial/Insurance Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Palmieri Chiropractic and Rehabilitation will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that insurance claim submission is not a guarantee of payment and that I am responsible for all services rendered to me at the time of service including but not limited to: deductible, co-payments, or any products or services not covered by my insurance.

I authorize Palmieri Chiropractic and Rehabilitation to release my information to the insurance company in an effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance reimbursements. I understand that after any initial promotional services all care is rendered at usual and customary fees. If care is suspended or terminated for any reason, any outstanding balance will become immediately due and payable.

I consent to receiving statements via email for any amount owed that is not paid at the time of service.

Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your written consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- You choose to decline receipt of your clinical summary after every visit and understand record requests can be made as needed.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

I consent to receiving text message and email communications regarding appointments, follow-ups and office updates.

Signature: _____ Date: _____

(Patient, Parent, or Legal Guardian)

Print Patient's Name _____ Relation to Patient: _____